

COVID-19 Pandemic Dental Treatment Consent Form

Patient name: _____

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that dental procedures create water spray which is one way that the novel coronavirus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. _____
(Initial)

I understand that due to the frequency of visits of other dental patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a dental office. _____ (Initial)

I voluntarily consent to today's required COVID-19 assessment and I understand my right for refusal. If I choose to refuse today's COVID-19 assessment, I understand my treatment would be postponed to a later date _____ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 identified by **Ontario** Health Services:

Fever > 38°C _____ (Initial)

Cough _____ (Initial)

Sore Throat _____ (Initial)

Shortness of Breath _____ (Initial)

Flu-like symptoms _____ (Initial)

I confirm that I am not currently positive for the novel coronavirus. _____ (Initial)

I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus. _____ (Initial)

I verify that I have not returned to **Ontario** from any country outside of Canada whether by car, air, bus or train in the past 14 days. _____ (Initial)

I understand that any travel from any country outside of Canada, including travel by car, air, bus or train, significantly increases my risk of contracting and transmitting the novel coronavirus. **Ontario** Health Services require self-isolation for 14 days from the date a person has returned to Canada. _____ (Initial)

I understand that **Ontario** Health Services has asked individuals to maintain social distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive dental treatment. _____ (Initial)

I verify that I have not been identified as a contact of someone who has tested positive for novel coronavirus or been asked to self-isolate by **Ontario**, Public Health, the Communicable Disease Control or any other governmental health agency. _____ (Initial)

LIST of DENTAL TREATMENT

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have the above listed emergency dental treatment completed during the COVID-19 pandemic.

SIGNATURE OF PATIENT

SIGNATURE OF PARENT/GUARDIAN

Printed Name _____

Date _____